

THE IHS PRIMARY CARE PROVIDER



October 1995

Volume 20, Number 10

Indian Self-Governance Going Through the Compacting Process

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Introduction

The Self-Governance process is one that can promote tribal sovereignty, improve health care, maximize tribal involvement in developing and managing programs, and enhance relationships between health care workers and the population served. This article presents the observations of a physician with 18 years of experience in the Indian Health Service (IHS), who has gone through this process with the Quinault Nation. There is no intent to suggest to either tribes or the IHS how it "should" be done, as there are numerous experts who can do that far better.

The Pre-Negotiation Phase (Will We or Won't We Compact?)

Each tribe will weigh the advantages and disadvantages of compacting, including funding issues. Each tribe will consider the total dollars potentially available, although at this early stage (prior to negotiations) one can only approximate this figure. If the tribe is already involved with "638-contracting," the approximate dollar figure will already be known. If health care to-date has all been provided by the Indian Health Service, then the IHS should be able to provide an approximate figure.

There is a "critical level" of health care dollars, below which it is impractical to think of operating an effective health care system. Generally, this will depend upon the user population. It is my impression that when the user population exceeds 1000, the amount of funding available is sufficient to consider compacting as a self-governance

program, although even smaller populations may be able to effectively develop a program, either by themselves, or along with other small groups. Just as a tribe will have a "critical" level, so will IHS have a "critical" level, below which it would be unable to provide adequate programs to those tribes who do not choose to compact.

Tribal leaders will have had discussions with the IHS in order to have as accurate an idea as possible about what funding will be available. They will also be in close touch with other tribes that have gone the Self-Governance route, so that they have a good idea of what is involved and what the necessary steps are.

Having carefully considered the pros and cons, and having a sense of the will of their people, the time arrives for making a decision. It is important to complete this phase as quickly as possible, so as not to allow the "rumor mill" to lower morale and hamper the delivery of efficient, quality services. A firm decision and a precise announcement, combined with a good public relations effort, will clear the air and remove doubts from everyone's minds. Now is the time to move to the next phase.

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Negotiation Phase (Yes, We Are Going to Compact!)

As mentioned, a clear statement of intentions is very helpful in smoothing the process. Along with this statement of intention, it is helpful to give a clear target date. Only with very hard work can this phase be completed in less than 6 to 8 months; almost always, it can be done in less than 12 months.

Meetings between the IHS and the compacting tribe to allow for adequate planning for the transfer of administrative responsibilities will certainly be frequent. It is important that the tribe will have clearly identified its coordinators and leaders of this effort. Those selected must be knowledgeable about all aspects of the compacting process, and committed to the process. It is very helpful to have one individual, along with a designated back-up, identified as the key person in keeping the process on track. This individual must have negotiation skills, firmness, sensitivity, knowledge about health care and personnel issues, and the respect of tribal leaders and health care personnel.

As early as possible in this process, it is desirable to have many conferences, group and individual, with **every** individual currently employed in the health facility to clarify their employment options. It would be reassuring to current personnel if a verbal *and* written statement could be provided by the tribe assuring them of their ability to continue employment in the tribally-managed program. In addition, detailed information should be provided about the salary and benefits package remaining employees can count on. On the other hand, it is very possible there may be some individuals whom the tribe does not want to have continue. If so, those individuals can be informed as tactfully as possible, and as early as possible, about this. By having early and frequent communication with employees, it will be possible to squelch the many rumors that are likely to arise, and which can be so disruptive to ongoing health services.

It is important that the IHS also confer with its personnel, making each Civil Servant and Commissioned Officer aware of what his or her options are. It is desirable that this be clarified *very early* in the process. By so doing, there is a greater likelihood of retention of personnel, or, in the case of transfer or retirement, more time to recruit replacements. It is generally assumed that most personnel in the new system will be tribal employees, but, if there are to be Intergovernmental Personnel Agreements (IPAs) for Civil Servants, or Memorandums of Agreement for Commissioned Officers, each employee must understand what the time limits on such arrangements are, and who their immediate supervisor will be under the new system.

Once current personnel know their options, they can make an earlier decision about remaining or leaving. Regarding retention of current employees, it is very helpful to have a lot of community input to encourage retention. Picnics, potlucks, and other special programs involving

many individuals in the community, sometimes with special recognition and awards, might help to reassure personnel, and to encourage them to stay. The more employees who stay through the transition, the smoother it will be, and the more likely we are to meet the vision stated by the Director of the IHS, that as change occurs, the customer, the American Indian and Alaska Native patient, only notices "improved quality of care."

With the knowledge of who is staying and who is leaving, it is possible to initiate serious recruiting. To do this, it is necessary to review all job descriptions and conditions of employment. Some of the old IHS job descriptions will still be adequate. But for most, it will be necessary to modify these. This can be an opportunity to depart from some of the unnecessary bureaucracy and come up with fresh statements of duties and functions that reflect the reality of tribal management and that may be clearer and more attractive to potential candidates for employment.

It will require the best available individuals to write these job descriptions, and it will require a lot of communication with tribal personnel departments in order to clearly identify the salary and other benefits. This information must be available if one hopes to secure commitments from current employees or potential new hires to fill essential positions. When a good candidate for employment appears, and the decision to hire can be made, there must be no delay in making an offer, since good candidates will not wait around; they will simply go elsewhere. *Be prepared to snap up good candidates!*

The negotiating team will have been identified by the tribe. Most tribes have very capable personnel to do this, and they are able to look out for their own interests very well. They must be willing to push IHS all the way in identifying all aspects of programs, and all potential dollars being expended, including those locally, as well as in the Area Office and at Headquarters in Rockville, Maryland. The IHS will be watching out for its own interests, its "critical" level that permits it to continue serving those tribes that choose not to compact or contract.

By now, negotiations are well along, we are nearing the time for the actual transition, and it is imperative to ensure that essential health services are provided for throughout this period.

Transition Phase (Transfer of Responsibilities Takes Place)

The transition phase begins during the four to six weeks prior to actual initiation of Self-Governance management. Those personnel who have decided to leave may be gone by now. It is vital to ensure that the gaps are filled or that the program is adjusted to match the personnel available. In small clinics, the absence of just one individual, such as a nurse, a physician, a lab technician, or a secretary, can make all the difference in the world in the quality and/or quantity of services that can be provided. If

there are critical vacancies, every effort should be made to secure temporary personnel until permanent personnel can assume these positions. This may require additional funds, and it is important for IHS to assist in identifying additional transition funds if the need arises.

During the transition, some personnel may be asked to perform additional duties. For example, there may be the need to designate an "Acting Service Unit Director," an "Acting Clinical Director," or an "Acting Business Office Supervisor." These individuals will no doubt be very capable persons; but they already have their own duties. Recognizing this and providing for sufficient time in the day and week for them to assume some of these additional duties would help reduce stress and frustration, make the transition progress more smoothly, and ensure that quality health care services are maintained. Sometimes patient loads can be adjusted (elective patient concerns) by changing clinic schedules, not-so-essential duties might be temporarily delegated to other personnel, or an employee from another facility may be temporarily available to help out ("Temporary Duty," known as "TDY").

Recognition of both departing and incoming personnel would help all staff members to get through this turbulent period. Be careful to omit no one. Farewell parties or potluck dinners and other expressions of appreciation, including cards, letters, and special recognition awards, will create a positive environment for all concerned. As mentioned earlier, the more community participation there is, the better. New personnel should be made to feel welcome. An adequate orientation, not only to the clinical program, but also to the tribe and the tribal government and its programs, would help new personnel feel more comfortable and make "fitting in" quicker and easier. If the process goes well, there should be a feeling of cohesiveness among all personnel, a new *esprit de corps*, a blending of the former "us" (IHS employees) and "them" (the tribal government) identities, and a new community pride of ownership ("This is our clinic.").

Meetings between the tribe and IHS will continue throughout this transition phase. Formal recognition of the transfer of responsibilities provides an opportunity to recognize past important contributions and to set the stage for future collaboration between the IHS and the tribe. Participation of community members, including elders, and the health facility staff in this formal recognition (perhaps an "open house" party) further enhances the positive tone needed for a smooth transition.

Post-Transition (We Are Now Under Tribal Management)

The processes of revising job descriptions, filling vacant positions, and orienting new employees continues. The tribe continues to meet regularly with IHS. The managers or directors may be new to the clinic and new to the program, or they may be familiar persons who have filled these roles before. In any case, it is a new era; many things function differently, and personnel are feeling their way along. It can be an uncertain and, sometimes, frightening time. Everyone needs to "pull together," to continue to offer high quality services to the population served. People at all levels need encouragement. Tribal government leadership can contribute a great deal in this process, and so can Indian Health Service leadership.

Nationwide, it is conceivable that direct IHS services will eventually be phased out; but for now, the Indian Health Service continues to be a strong resource for tribally-managed health programs. The lines of communication need to remain open. The negotiation process may have resulted in some bruised feelings; there may be some resentment and antagonism. All of these must be overcome, because they are outweighed by the benefit to American Indian and Alaska Native patients, and there is much to be gained by ongoing collaboration. The goal of the IHS continues to be to work with tribes to raise the health status of American Indians and Alaska Natives to the highest possible level. There is much yet to be done. ■



Indian Self-Determination

Defining Contracting and Compacting

Editor's Note: *The following information was gathered by the editors from a variety of sources including the IHS Office of Self-Governance, the IHS Office of Tribal Activities, and the Chief Medical Officer of the IHS Phoenix Area. The intent of the editors was to help health care providers understand the purpose behind self-determination and the similarities between compacting and contracting by offering a brief summary rather than an exhaustive review of the subject. In writing this, the editors made the following assumptions: that health care providers want to know how the law will affect their personal lives and that they do not need or want to know the complicated details of the law.*

The Law

Public Law 93-638 begins:

To provide maximum Indian participation in the Government and education of the Indian people; to provide for the full participation of Indian tribes in programs and services conducted by the Federal Government for Indians and to encourage the development of human resources of the Indian people; to establish a program of assistance to upgrade Indian education; to support the right of Indian citizens to control their own educational activities; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Self-Determination and Education Assistance Act."

CONGRESSIONAL FINDINGS

Sec.2.(a) The Congress, after careful review of the Federal Government's historical and special legal relationship with, and resulting responsibilities to, American Indian people, finds that—
(1) the prolonged Federal domination of Indian service programs has served to retard rather than enhance the progress of Indian people and their communities by depriving Indians of the full opportunity to develop leadership skills crucial to the realization of self-government, and has denied to the Indian people an effective voice in the planning and implementation of programs for the benefit of Indians which are responsive to the true needs of Indian communities; and

(2) the Indian people will never surrender their desire to control their relationships both among themselves and with non-Indian governments, organizations, and persons.

(b)

This Act, passed in 1975 and amended several times since, provides specific guidelines for the implementation of contracts and compacts between the federal government and individual tribes for the purpose of ensuring direct participation in the provision of federal services.

Self-Determination Contracting

Title I, part of the original and permanent legislation, permits any tribe to contract with the federal government, thus allowing them to take over the planning and implementation of any or all federal services (Indian Self-Determination). Contracting tribes can request permission from the Indian Health Service (IHS) to redesign those parts of the health care system they will be responsible for; however, IHS can deny this request. All tribes contract with the IHS to some degree; examples include tribal alcohol programs, emergency medical services programs, and Community Health Representative programs. Some tribes contract to provide all health services.

Self-Determination Compacting

To give American Indians and Alaska Natives more independence and power related to the planning and implementation of federal services, Congress, in amendments to PL 93-638 passed in 1988 (Sections 302 and 307 of Title III), required the Secretary of the Interior and the Secretary of Health and Human Services to conduct a research and demonstration project (known as the Tribal Self-Governance Demonstration Project) for a period not to exceed eight years. The Secretaries were to select 30 tribes to participate in this Project that would allow them to negotiate annually for and enter into funding agreements to take over the planning and delivery of some or all federal services (compacting). Compacting tribes can redesign any or all of those services they are compacting for as long as funds are used for health services. A very simplistic comparison of contracting and compacting is shown in Table 1.

Contracting or Compacting and Federal Employees

At the time a tribe first contracts or compacts for

Table 1. Similarities of contracting and compacting

Contracting (Title I)	Compacting (Title III)
Permanent legislation.	Currently a demonstration project for IHS, although it is now permanent for the Bureau of Indian Affairs (BIA).
Any tribe may submit a proposal.	Limited number of tribes allowed to participate. They must meet certain prerequisites (including having operated two or more mature contracts), and be selected to participate.
The IHS has 60 days to decline or 90 days to award a contract proposal.	No specified time limit.
The tribe can contract to take over planning and implementation of any or all programs.	Facilities construction may not be compacted.
Contracts are not subject to the Federal Acquisition Regulations (FAR), with the exception of construction contracts.	Same.
Tribe granted title to Federal real and personal property for use in carrying out the contract.	Title to real and personal property not available to Title III.
The tribe can request, in the contract proposal, to redesign the health care delivery system. IHS can decline, but has the burden of proof.	The tribe can redesign the health care delivery system.
The tribe is entitled to any and all Headquarters and Area Office shares related to the scope of their contract, or they may elect to leave any or all their shares in order to continue to receive program support, technical assistance, and consultation.	Same.
Reassumption and retrocession to the IHS can occur.	Reassumption is not covered.
Federal or tribal employees working within the scope of their employment are covered by the Federal Tort Claims Act for malpractice. The only gray area is if health services are routinely offered by the tribal program to non-beneficiaries.	Same.

specific services, the tribe may offer current personnel the opportunity to remain and work for the tribe. In many cases, individuals will remain Federal employees for an indefinite period of time. This is accomplished by detailing a Civil Service employee, through an Intergovernmental Personnel Agreement (IPA) or by assigning a Commissioned Corps employee through a memorandum of agreement (MOA).

Current Status

In fiscal year (FY) 1995, there were 29 compacts* and approximately 630 contracts with the IHS.

Summary

Tribes have the leadership role in the planning and delivery of services for which they have contracted or

compacted under Title I and Title III of P.L. 93-638, as amended. The net effect on providers of health care services to American Indians and Alaska Natives is pretty much the same, regardless of whether they are employed by a tribe under a P.L. 93-638 contract or compact. Those effects can be summarized as follows:

- 1) The responsibility for the administration and provision of specific services is transferred from the Federal government to the tribes.
- 2) Personnel can remain Federal employees for an indefinite period of time. A change of employment status from that of Federal employee to that of tribal employee, however, may eventually take place.
- 3) At the time that the tribe first contracts or compacts for specific services, the tribe may or may not ask current employees to remain in their positions.
- 4) There is a potential for changes in health care priorities, as determined by the specific tribe(s) involved.
- 5) There is a potential for being better able to meet the local community's health care needs. ■

* Twenty-eight individual tribes have entered into 28 separate compact agreements with the IHS. The 29th compact involves the state of Alaska where a total of 13 villages, consortiums, or corporations representing some 200 tribes entered into one compact agreement with the IHS.

Nursing in the Alaska Bush

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I sit for hours in the air terminal lobby in Bethel waiting for the weather to clear. Several flights farther out on the Bering Sea have already been canceled "due to weather." My destination is a small island only fifteen flight minutes away on the Kuskokwim River. The flight may still go – if only to deliver mail. I have chosen this particular time to visit the village because the river will soon freeze and it may be two months before the ice will be frozen solid enough to safely cross with snow-machines.

Another passenger saunters over to the bush map on the wall next to me. It turns out that he's going to another village only five more air minutes down the Yukon Delta Wildlife Refuge Johnson River. It's his first trip out from Anchorage in six years. After we get clearance to fly and become airborne, the weather begins to deteriorate. The fog gets thicker and begins to rush past the plane in thick pockets. We use pieces from an old cutup sweatshirt found in the seat pockets to try to clear the fog off the windows of the four-seater Cessna 207. The pilot banks right, then left; clearly he's lost! Hundreds of lakes are visible below us, as we all try to pick out the little ribbon of an airstrip on the fog-ridden tundra. Ironically, the pilot had commented as we boarded, "This is my last flight in the Delta. I'm transferring." Although he has been flying over the Delta for three months, he is unfamiliar with this part of it. Finally the other passenger spots the airstrip, signals to the pilot, and we make our go-round and approach for landing.

The village airline agent for bush pilots meets the plane with a four-wheel ATV, pulling a cart. It's pouring

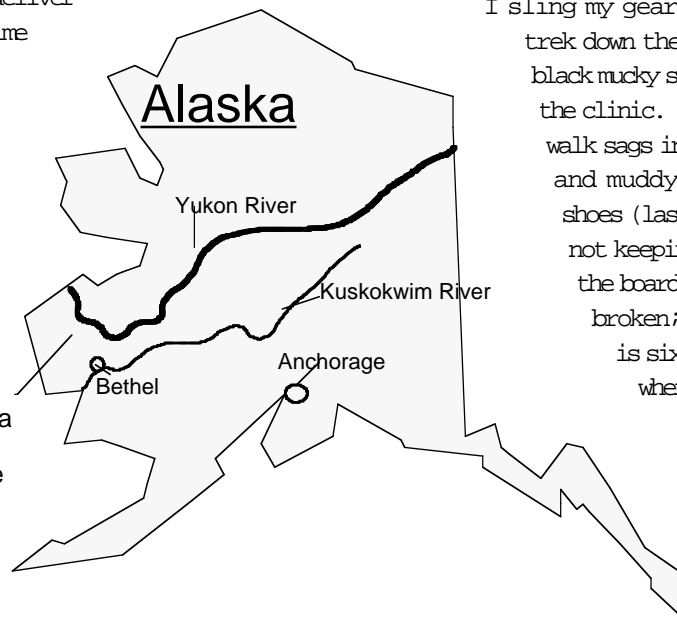
rain as I scoot outside over the edge of the plane's doorway. I throw my sleeping bag and gear into the cart and sit on the bag to absorb the shocks of the unpaved, rough road down to the river. At the river's edge, I climb into the boat. The river taxi revs up the motor to full speed, and we veer from the slough into the main river channel. We quickly reach the opposite shore near a boardwalk where the small anchor is wedged to the boardwalk so I can climb ashore.

I sling my gear over my shoulders and trek down the boardwalk covering the black mucky soil of the tundra* over to the clinic. Along the way, the boardwalk sags in places under my weight, and muddy water rushes over my shoes (last spring's "Sno-Seal"† is not keeping my feet dry). Some of the boards are missing, others are broken; although the boardwalk is six boards wide, I must watch where I place my feet.

I arrive at the back door to the clinic and find it jammed. No one answers my call for assistance; I can't get my gear inside out of the rain. The Clinic

Manager suddenly appears and says, "There is an emergency. You're to come!" I hear the panic in his voice.

I am soaked from the drenching river ride in the rain. The large black plastic trash bag "rain coat" is flapping around my neck. I'm wondering, Will it be another laceration? In the last two villages I visited, there were four traumas involving lacerations. At least they waited until I arrived in the village. Surely not a village birth!



* Tundra is defined as a level, treeless plain that is characteristic of arctic and subarctic regions, consisting of black mucky soil with a permanently frozen subsoil. Homes and sidewalks cannot be built directly on the tundra.

† "Sno-Seal" is a leather sealant used to waterproof shoes.

I try to keep step with the small-statured Yup'ik Eskimo who is weaving through the village boardwalks. Oops! Wrong house. We go back and, two doors down, we find the right house.

I go into the house and through the second door on the right, off of a darkened hallway, where I find the patient in a small bedroom. The room is in disarray, with loose clothing piled high and strewn around the walls. The patient is lying on the bed with a village health aide bending over her. As he looks up, I ask, "What's the problem?" "A birth," he answers. "Where's the baby?" He points; he has wrapped the baby in a blanket and placed it over the mother's pelvis. I can hardly see in the poor light. My eyeglasses are steamed over and frozen; I need a few minutes before I can see clearly.

The portable obstetrical pack has been opened. The clamps are placed on the umbilical cord. The health aide looks nervous but I assure him it's okay, and he cuts the cord. The cord's blood vessels are counted, the mom's abdomen is massaged, and the afterbirth is saved for later examination.

As I continue my efforts to warm the baby, I learn there is no heat in the house. You can feel the Arctic winter approaching although it's only the last day of August. The only adult male in the house lights the propane stove and boils water. I am not sure if he is the father of the newborn.

The health aide uses the family's VHF radio to contact the on-call doctor back at the hospital in Bethel. The doctor returns the urgent call and the health aide asks me to take the phone. I estimate the Apgar score of the baby on my lap as I talk. The physician orders the two patients (mother and baby) to be transported by aeromedical evacuation aircraft into Bethel for evaluation. The established protocol for the village aides requires that the aide go along as an escort for the patient. The health aide turns to me, "Will you help me?"

The baby has been wiped off and is now looking very pink. The bath is deferred until arrival at the hospital. The baby's head is now protected with one of a new pair of her grandmother's socks. Four threadbare flannel blankets are found in a grocery bag. I use these plus a larger infant comforter borrowed from another baby's crib to swaddle the baby.

A bush pilot plane is chartered for the patients, and the pilot plans to pick them up in thirty minutes. I watch for the plane from the doorway. As soon as the plane is spotted, the patients are prepared for the trip. I slip the baby down into doubled plastic bags for protection from the rain and wind on the river ride back to the airstrip. A wheelchair is retrieved from the village clinic and the new

mom is pushed down the boardwalk to the family's boat. We all climb into the boat and I pull the edge of the tarp protecting the mom over to cover the baby. As the boat speeds across the river, I keep monitoring the baby's movements. Occasionally I peek inside the plastic bags, being careful not to let the wind in.

At the boat landing near the airstrip, the two men push the new mother (who is holding the afterbirth secured in a plastic bag) in a wheelchair up the loosely gravelled, rough road toward the airstrip. I can feel the baby react to the wind, so I unzip my jacket and slip the baby down inside to absorb warmth from me. I walk faster toward the plane now on the runway and I'm almost out of breath.

The pilot is standing under the wings. "Whatcha got there?" he asks. "A baby, born an hour ago," I reply. He apparently had not been informed of the nature of his emergency flight and now has to reoutfit the plane. He unfolds seats from the baggage compartment and slips them onto the plane seat railing. The mom and health aide climb aboard, seat belts are latched, and I pass the baby over. The plane taxis down the runway and soon roars by overhead. I wave both arms to them.

The uncle of the baby pushes the empty wheelchair back to the boat. I follow and climb back into the boat. I now face the rain, wind, and cold of the river for the third time in two hours. We reach the opposite shore, and again the anchor is wedged into the boardwalk. I walk back to the clinic. It's well past my lunch time. I smear a hamburger bun with canned tuna salad and wash the sandwich down with a pouch of punch (items I had brought with me from home).

Left alone, I see patients in clinic the rest of the afternoon, and the evaluations that I came to do are performed. While the janitor cleans the clinic, I lie down in the itinerant quarters and doze.

I hear voices. The health aides have returned to view the videotape of the movie, "The Fugitive," that I had brought along for their evening entertainment. We open a large can of peanuts and get involved with the movie. As the movie's end approaches, one aide starts to slip on her coat and shoes. "I have to go, my husband has made me a steam bath." The movie ends and both health aides don large green plastic bag raincoats and walk out into the Arctic darkness side by side. I watch until they disappear from sight.

As I open another pouch of punch, I think about how this day has captured the spirit of community health nursing in the remote bush of Alaska. I feel challenged and exhilarated; it's a good feeling. ■

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The Provider is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 640-2140; Fax: (602) 640-2138. Previous issues of *The Provider* (beginning with the December 1994 issue) can be found on the IHS health care provider home page (<http://www.tucson.ihs.gov>)

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Circulation: *The Provider* (ISSN 1063-4398) is distributed to more than 6000 health care providers working for IHS and tribal health programs, to medical and nursing schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive *The Provider*, free of charge, send your name, address, professional title, and place of employment to the address listed below.

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